STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	G	01	COMPL	ETED	
		155782	B. WING			01/17/	2013
NAME OF D	DOMEST OF CLIPPINE	D.	ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	K	81	14 S 6	TH ST		
WHITE C	OAK HEALTH CAM	PUS	М	ONTIC	CELLO, IN 47960		
(X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
K0000							
	A Life Safety C	ode Recertification	K0000		Submission of this plan of		
	· ·	nsure Survey was			correction and credible allegation		
		the Indiana State			does not constitute an admissi	on	
	<u>-</u>				by the provider that the		
	Department of				allegations are a true and		
	accordance wi	th 42 CFR 483.70(a).			accurate portrayal of the provisions of care in this facility	•	
	Survey Date: (01/17/14		Please accept this plan as the same and our credible allegated of compliance. White Oak He		on	
	Facility Number	er: 012355			Campus submits this plan of		
	Provider Numb				correction as its letter of credit		
	AIM Number:				allegation and requests a desk		
	All Nulliber.	201014410			review with paper compliance considered in establishing the	be	
	Companyant Dela	leat Dearing 1:fa			provider is in substancial		
		lget Brown, Life			compliance. We appreciate yo	ur	
	Safety Code Sp	Decialist			consideration of this request.		
	At this Life Saf	ety Code survey,					
	White Oak Hea	alth Campus was					
	found not in c	ompliance with					
	Requirements	for Participation in					
	Medicare/Med	icaid, 42 CFR					
	Subpart 483.7	0(a), Life Safety					
	-	the 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
		napter 18, New					
		•					
	Health Care Occupancies and 410						
	IAC 16.2.						
	The one story	facility was					
		be Type V (111)					
		nd fully sprinklered.					
	construction a	ila lally sprilikierea.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

012355

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF CORRECTION OF CORRECTION 155782	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 01/17/2013		
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
	The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors and in resident rooms. The SNF certified health care occupancy was located on north end of the main building with a capacity of 55 residents and a census of 48 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/13. The facility was found not in compliance with the aforementioned requirements as evidenced by:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/17/2013		
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 8 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 21 residents in the 200 hall smoke compartment. Findings include: Based on observation with the maintenance director and administrator on 01/17/13 at 2:05 p.m., the double door set providing access to the 200 hall linen storage room each required one door to latch into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not latch independently into the door frame.	K0018	1. No residents were found to have been affected.2. Resider that reside on 200 unit have the potential to be at risk of allege deficient practice. 3. The 200 doors identified are the only double door set at the facility. Director of Plant Operations (DPO) will check the doors for proper closure and document his monthly rounding audit tool. Audit results will be broug to monthly Quality Assurance (QA) Meeting. Trends will be reviewed by QA Committee 6 months or until 100% compliance is achieved.	ne d unit 4. on		

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PRINTED: 02/05/2013 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CO		(X3) DATE SURVEY	
l 155700		A. BUILDING	01	COMPLETED	
		155782	B. WING		01/17/2013
NAME OF F	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CODE	
WHITE	OAK HEALTH CAM	PHS	814 S 6	STH ST CELLO, IN 47960	
				OLLLO, IIN 47 300	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
		,			
	3.1-19(b)				
	3.1 13(6)				

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	f í
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
155782 B. WING	01/17/2013
STREET ADDRESS, CITY, STATE, Z	ZIP CODE
NAME OF PROVIDER OR SUPPLIER 814 S 6TH ST	
WHITE OAK HEALTH CAMPUS MONTICELLO, IN 47960	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIVE	THE APPROPRIATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	DATE DATE
K0050 NFPA 101	
SS=C LIFE SAFETY CODE STANDARD	
Fire drills are held at unexpected times under varying conditions, at least quarterly	
on each shift. The staff is familiar with	
procedures and is aware that drills are part	
of established routine. Responsibility for	
planning and conducting drills is assigned	
only to competent persons who are qualified	
to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	
announcement may be used instead of	
audible alarms. 18.7.1.2	
Based on record review and $K0050$ 1. No residents hav	ve been found 02/16/2013
interview, the facility failed to	
facility have the pot	
at unexpected times under varying risk for the alleged practice. 3. Director	
conditions during 4 of 4 quarters.	
This deficient practice affects all	
the year.4. DPO will	
occupants. Trilogy Fire Drill Re	
times of fire drills in the varied times for Fire Drill Record will monthly Quality Apr	r the year. The ill be brought to
Based on a review of Fire Drill monthly Quality Ass	
Reports provided for the past year by the QA Committee	te x 6 months
with the administrator and	oliance is
maintenance director on	
01/17/13 at 3:55 p.m., fire drill	
times varied less than an hour for	
all four quarters for the first and	
second shifts. Drills during the	
second shift were conducted at	
2:00 p.m., 2:55 p.m., 2:31 p.m.,	
and 2:30 p.m. First shift drills	
were conducted at 10:25 a.m.,	
10:00 a.m., 10:30 a.m., and 10:17	

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	OF CORRECTION OF CORRECTION 155782	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 01/17/2013		
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION		
	a.m. Night shift drills were conducted at various times. The administrator and maintenance director agreed the drills did not occur at unexpected times. 3.1–19(b) 3.1–51(c)					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01 CO		COMPL	COMPLETED	
155782		155782	B. WIN			01/17/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				814 S 6			
WHITE OAK HEALTH CAMPUS					CELLO, IN 47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0062 SS=F	continuously mair condition and are periodically. 18.7 NFPA 25, 9.7.5 Based on obser	tic sprinkler systems are ntained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13,	K00	62	No residents were found to have been affected.2. Resider		02/16/2013
	failed to ensure hydrants provide supplement the sprinkler system annually. NFPA hydrants shall to ensure propeach hydrant shall and water flow material has clean	e 1 of 1 fire ding water to e automatic m was tested A 25, 4-3.2 requires be tested annually er functioning. hall be opened fully ed until all foreign eared. Flow shall for not less than his deficient s all occupants.			residing at the facility have the potential to be affected by the alleged deficient practice.3. The City of Monticello has sent the facility a letter on letterhead the states they will be responsible flushing the hydrant behind ou property.4. Director of Plant Operations will add this to the Preventative Maintenance Program binder with annual equipment to be tested. Result will be brought to Quality Assurance Committe to ensure compliance x 6 months or until 100% compliance is achieved.	ne at for r	
	Based on obsermaintenance diadministrator of 1:15 p.m., a fir located behind on a review of ETest and Maint with the mainteadministrator of	rvation with the irector and on 01/17/13 at					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155782	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI	E SURVEY PLETED 7/2013	
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	flushing of the hydrant. The maintenance director said at the time of record review, he didn't know if the hydrant was facility owned and did not know if it had been flushed. 3.1–19(b)					

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CROSS-REFERENCED TO THE APPROPRIATE	
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	(X5) DMPLETION DATE
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 STREET ADDRESS, CITY, STATE, ZIP CODE STANDARD STREET ADDRESS, CITY, STATE, ZIP CODE STANDARD ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960 COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960	DMPLETION DATE
WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	DMPLETION DATE
WHITE OAK HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD MONTICELLO, IN 47960 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I SS=E LIFE SAFETY CODE STANDARD	DMPLETION DATE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	DMPLETION DATE
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 S=E LIFE SAFETY CODE STANDARD	DMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	DATE
K0069 NFPA 101 SS=E LIFE SAFETY CODE STANDARD	
SS=E LIFE SAFETY CODE STANDARD	2/16/2013
33 2	2/16/2013
Cooking facilities are protected in	2/16/2013
accordance with 9.2.3. 18.3.2.6, NFPA 96	2/16/2013
	2/10/2013
Based on observation and interview, the facility failed to $K0069$ 1. No residents were found to have been affected 2. Residents	
provide the minimum protection residing at the facility have the	
provide the minimum protection potential to be affected by this	
between 2 of 2 commercial alleged deficient practice.3. A	
cooking appliances in the kitchen. splashguard will be installed on	
NFPA 96, 9–1.2.3 requires deep the deep fryer in the kitchen. This is the only fryer in the facility. 4.	
fat fryers shall be installed with at Director of Plant Operations will	
least a 16 inch space between the document compliance of	
fryer and surface flames from separation between the fryer and	
adjacent cooking equipment the range on the monthly	
Preventative Maintenance	
except where a steel or tempered rounding tool. Results will be	
glass baffle plate is installed at a brought to monthly Quality	
minimum of eight inches in height Assurance (QA) Meetings. Trends will be reviewed by QA	
between the adjacent appliances.	
This deficient practice could affect	
5 kitchen staff.	
Findings include:	
Findings include.	
Based on observation of the	
commercial cooking appliances in	
the kitchen with the maintenance	
director and dietary manager on	
01/17/13 at 2:25 p.m., the	
minimum separation of 16 inches	
or separation by a steel or	
tempered glass baffle plate was	
not provided between the range	
and fryer which were located side	
by side. The range was eight	

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	of Correction identification number: 155782	A. BUILDING B. WING	01	COMPLETED 01/17/2013
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	814 S 6	ADDRESS, CITY, STATE, ZIP COD STH ST CELLO, IN 47960	E
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION
	inches from the fryer. The shield provided to separate the two appliances was four inches tall. The maintenance director and dietary manager said at the time of observation, they were unaware the separation requirements had not been met. 3.1–19(b)			

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